

AMENDED IN SENATE MAY 30, 2002  
AMENDED IN SENATE AUGUST 20, 2001  
AMENDED IN SENATE JULY 5, 2001  
AMENDED IN SENATE JUNE 25, 2001  
AMENDED IN ASSEMBLY APRIL 16, 2001

CALIFORNIA LEGISLATURE—2001–02 REGULAR SESSION

**ASSEMBLY BILL**

**No. 1401**

**Introduced by Assembly Member Thomson**

February 23, 2001

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~~An act to amend Section 1399.818 of, to amend, add, and repeal Sections 1366.27 and 1366.35 of, to add Sections 1366.29, 1366.34, 1366.40, and 1366.61 to, and to add and repeal Article 10.5 (commencing with Section 1399.801) of Chapter 2.2 of Division 2 of, the Health and Safety Code, and to amend Sections 10902.6, 12705, 12711, 12725, and 12726, to amend, add, and repeal Sections 10128.57 and 10785 of, to add Sections 10128.59, 10784, 10786, 12672.1, and 12712.5 to, and to add and repeal Chapter 9.5 (commencing with Section 10900) of Part 2 of, and Chapter 7.5 (commencing with Section 12738.1) of Part 6.5 of, Division 2 of, the Insurance Code, relating to health coverage. An act to amend, repeal, and add Section 1373.6 of, to add Sections 1348.5, 1363.06, 1366.29, and 1372.1 to, and to add and repeal Section 1373.62 of, the Health and Safety Code, and to amend Sections 12678, 12689, 12711, 12725, 12739, 12739.1, and 12739.2 of, to amend and repeal Sections 12682, 12683, 12684, and 12685 of, to add Sections 10113.8, 10127.14, 10128.59, and 12682.5 to, and to add and repeal Sections 10127.15 and 12712.5 of, the~~

*Insurance Code, relating to health care coverage, and making an appropriation therefor.*

## LEGISLATIVE COUNSEL'S DIGEST

AB 1401, as amended, Thomson. Health benefit coverage.

(1) The California COBRA Program (Cal-COBRA) and other provisions of existing law require health care service plans and ~~disability~~ health insurers to offer health benefit coverage to specified individuals who are without that coverage. Existing law also creates the Managed Risk Medical Insurance Board ~~which~~ that administers the California Major Risk Medical Insurance Program (MRMIP) to provide major risk medical coverage to residents who are unable to secure adequate private health coverage. *Under existing law, designated amounts from the Cigarette and Tobacco Products Surtax Fund are deposited annually into the Major Risk Medical Insurance Fund, which is continuously appropriated to pay for the MRMIP expenses.* Existing ~~provisions of federal law impose~~ imposes requirements relating to the obligation of a health insurance issuer ~~that offers health insurance in the individual market, to provide coverage through a converted policy to certain individuals who had prior after they become ineligible for coverage through a group plan and under that law, a state may implement those requirements through an acceptable alternative mechanism approved by the federal government.~~

This bill would ~~create an alternative mechanism by revising~~ revise certain provisions of Cal-COBRA and other existing laws that require plans and insurers to offer health benefit coverage to certain individuals. The bill, in this regard, would, *effective March 31, 2003, revise coverage requirements for converted policies and would also require a health care service plan and a health insurer to offer specified individuals who have exhausted their continuation coverage under Cal-COBRA or federal continuation coverage provisions an opportunity to extend the term of their coverage to 36 months. The bill additionally would establish a standard benefit plan 4-year pilot program, commencing March 31, 2003, and terminating July 1, 2007, requiring that health care service plans and disability health insurers would be required to offer to specified individuals, including those who had exhausted their benefits under Cal-COBRA and MRMIP. The bill would require that the standard benefit plan be approved by MRMIB and that MRMIB also approve its plan rate. The bill would specify that*

~~its health care service plan provisions pertaining to the alternative mechanism would become operative 6 months after their approval by the federal government and would become inoperative 36 months thereafter, and that its disability insurance provisions pertaining to the alternative mechanism would become operative 36 months after their approval by the federal government and would become inoperative 42 months after that approval by the federal government~~ *a standard benefit plan, based on benefit designs offered through the MRMIP. Under the pilot program, plans and insurers would be precluded from rejecting an application for coverage from an individual who was previously covered under the MRMIP for a period of 36 consecutive months. The bill would specify the amount of the subscriber contribution required in the pilot program and would require the board to make payments from the Major Risk Medical Insurance Fund to plans and insurers for the provision of health care services under the standard benefit plan. Because the bill would authorize the expenditure of funds in a continuously appropriated fund for a new purpose, it would make an appropriation. The bill would require the Legislative Analyst to report to the Legislature on the effectiveness of these provisions in providing health benefits to individuals who otherwise are unable to obtain that coverage. The bill would authorize the Managed Risk Medical Insurance Board to adopt emergency regulations to implement the provisions of the bill.*

(2) Under existing law, a violation of the provisions of Cal-COBRA or the Knox-Keene Health Care Service Plan Act of 1975, which regulates the operations of health care service plans is punishable as a misdemeanor offense.

Because this bill would impose additional requirements with respect to this act and Cal-COBRA, the violation of which would be punishable as a criminal offense, it would ~~expand the scope of an existing crime, thereby imposing~~ *impose* a state-mandated local program.

(3) The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: ~~no~~-yes. Fiscal committee: yes. State-mandated local program: yes.

*The people of the State of California do enact as follows:*

~~SECTION 1. Section 1366.27 of the Health and Safety Code~~

SECTION 1. *Section 1348.5 is added to the Health and Safety Code, to read:*

1348.5. (a) *The Department of Managed Health Care and the Department of Insurance shall compile information as required by this section and Section 10127.14 of the Insurance Code into two comparative benefit matrices. The first matrix shall compare benefit packages offered pursuant to Section 1373.62 and Section 10127.15 of the Insurance Code. The second matrix shall compare benefit packages offered pursuant to Sections 1366.35, 1373.6, and 1399.804 and Sections 10785, 12682.5, 12683, and 12684 of the Insurance Code.*

(b) *The comparative benefit matrix shall include:*

(1) *Benefit information submitted by health care service plans pursuant to subdivision (d) and by health insurers pursuant to Section 10127.14 of the Insurance Code.*

(2) *The following statements in at least 12-point type at the top of the matrix:*

(A) *“This matrix is intended to help you compare coverage and benefits and is a summary only. For a more detailed description of coverage, benefits, and limitations, please contact the health care service plan or health insurer.”*

(B) *“The comparative benefit matrix is updated annually, or more often if necessary to be accurate.”*

(C) *“If the health care service plan or health insurer maintains an Internet Web site, the most current version of this comparative benefit matrix is available on its site at (address of the plan’s or insurer’s site).”*

(3) *The telephone number or numbers that may be used by an applicant to contact either the department or the Department of Insurance, as appropriate, for further assistance.*

(c) *The Department of Managed Health Care and the Department of Insurance shall jointly prepare two standardized templates for use by health care service plans and health insurers in submitting the information required pursuant to subdivision (d) and subdivision (d) of Section 10127.14 of the Insurance Code. The templates shall be exempt from the provisions of Chapter 3.5*

1 *(commencing with Section 11340) of Part 1 of Division 3 of Title*  
2 *2 of the Government Code.*

3 *(d) Health care service plans shall submit the following to the*  
4 *department:*

5 *(1) A summary explanation of the following for each product*  
6 *described in subdivision (a).*

7 *(A) Eligibility requirements.*

8 *(B) The full premium cost of each benefit package in the service*  
9 *area in which the individual and eligible dependents work or*  
10 *reside.*

11 *(C) When and under what circumstances benefits cease.*

12 *(D) The terms under which coverage may be renewed.*

13 *(E) Other coverage that may be available if benefits under the*  
14 *described benefit package cease.*

15 *(F) The circumstances under which choice in the selection of*  
16 *physicians and providers is permitted.*

17 *(G) Lifetime and annual maximums.*

18 *(H) Deductibles.*

19 *(2) A summary explanation of coverage for the following,*  
20 *together with the corresponding copayments and limitations, for*  
21 *each product described in subdivision (a):*

22 *(A) Professional services.*

23 *(B) Outpatient services.*

24 *(C) Hospitalization services.*

25 *(D) Emergency health coverage.*

26 *(E) Ambulance services.*

27 *(F) Prescription drug coverage.*

28 *(G) Durable medical equipment.*

29 *(H) Mental health services.*

30 *(I) Residential treatment.*

31 *(J) Chemical dependency services.*

32 *(K) Home health services.*

33 *(L) Custodial care and skilled nursing facilities.*

34 *(3) The telephone number or numbers that may be used by an*  
35 *applicant to access a health care service plan customer service*  
36 *representative and to request additional information about the*  
37 *plan contract.*

38 *(4) Any other information specified by the department in the*  
39 *template.*

1 (e) Each health care service plan shall provide the department  
2 with updates to the information required by subdivision (d) at least  
3 annually, or more often if necessary to maintain the accuracy of the  
4 information.

5 (f) The department and the Department of Insurance shall  
6 make the comparative benefit matrices available on their  
7 respective Internet Web sites and to the health care service plans  
8 and health insurers for dissemination as required by Section  
9 1373.6 and Section 12689 of the Insurance Code.

10 SEC. 2. Section 1363.06 is added to the Health and Safety  
11 Code, to read:

12 1363.06. (a) Each health care service plan shall send copies  
13 of the comparative benefit matrix prepared pursuant to Section  
14 1348.5 on an annual basis, or more frequently as the matrix is  
15 updated by the department and the Department of Insurance, to  
16 solicitors and solicitor firms and employers with whom the plan  
17 contracts.

18 (b) Each health care service plan shall require its  
19 representatives and solicitors and soliciting firms with which it  
20 contracts, to provide a copy of the comparative benefit matrix to  
21 individuals when presenting any benefit package for examination  
22 or sale.

23 SEC. 3. Section 1366.29 is added to the Health and Safety  
24 Code, to read:

25 1366.29. (a) A health care service plan shall offer an  
26 individual who has exhausted continuation coverage under  
27 COBRA or Cal-COBRA, the opportunity to continue coverage for  
28 up to 36 months from the date the individual's continuation  
29 coverage began, if the individual is entitled to less than 36 months  
30 of continuation coverage under COBRA or Cal-COBRA. The  
31 health care service plan shall offer coverage pursuant to the terms  
32 of this article.

33 (b) Notification of the coverage available under this section  
34 shall be included in the notice of the pending termination of  
35 COBRA coverage that is required to be provided to COBRA  
36 beneficiaries and that is required to be provided under Section  
37 1366.24.

38 (c) In computing the amount of the premium charged to any  
39 specific employer group, the health care service plan shall not

1 *consider the specific medical expenditures for beneficiaries*  
2 *receiving continuation coverage pursuant to this section.*

3 *(d) For purposes of this section, "COBRA" means Section*  
4 *4980B of Title 26 of the United States Code, Sections 1161 et seq.*  
5 *of Title 29 of the United States Code, and Section 300bb of Title 42*  
6 *of the United States Code.*

7 *(e) This section shall not apply to specialized health care*  
8 *service plans.*

9 *(f) This section shall become operative on March 31, 2003.*

10 *SEC. 4. Section 1372.1 is added to the Health and Safety*  
11 *Code, to read:*

12 *1372.1. Each health care service plan that maintains an*  
13 *Internet Web site shall make a downloadable copy of the*  
14 *comparative benefit matrix described in Section 1348.5 available*  
15 *through its site and ensure that the most current update of the*  
16 *matrix is available on its site.*

17 *SEC. 5. Section 1373.6 of the Health and Safety Code is*  
18 *amended to read:*

19 *1373.6. This section does not apply to a specialized health*  
20 *care service plan contract or to a plan contract that primarily or*  
21 *solely supplements Medicare. The ~~commissioner~~ director may*  
22 *adopt rules consistent with federal law to govern the*  
23 *discontinuance and replacement of plan contracts that primarily or*  
24 *solely supplement Medicare.*

25 *(a) Every group contract entered into, amended, or renewed on*  
26 *or after January 1, 1985, that provides hospital, medical, or*  
27 *surgical expense benefits for employees or members shall provide*  
28 *that an employee or member whose coverage under the group*  
29 *contract has been terminated by the employer shall be entitled to*  
30 *convert to nongroup membership, without evidence of*  
31 *insurability, subject to the terms and conditions of this section.*

32 *(b) A conversion contract shall not be required to be made*  
33 *available to an employee or member if termination of his or her*  
34 *coverage under the group contract occurred for any of the*  
35 *following reasons:*

36 *(1) The group contract terminated or an employer's*  
37 *participation terminated.*

38 *(2) The employee or member failed to pay amounts due the*  
39 *health care service plan.*

1 (3) The employee or member was terminated by the health care  
2 service plan from the plan for good cause.

3 (4) The employee or member knowingly furnished incorrect  
4 information or otherwise improperly obtained the benefits of the  
5 plan.

6 (5) The employer's hospital, medical, or surgical expense  
7 benefit program is self-insured.

8 (c) A conversion contract is not required to be issued to any  
9 person if any of the following facts are present:

10 (1) ~~Such~~ The person is covered by or is eligible for benefits  
11 under Title XVIII of the United States Social Security Act.

12 (2) ~~The person is covered by or is eligible for hospital, medical,~~  
13 ~~or surgical benefits under state or federal law.~~

14 ~~(3) The person is covered by or is eligible for hospital, medical,~~  
15 ~~or surgical benefits under any arrangement of coverage for~~  
16 ~~individuals in a group, whether insured or self-insured.~~

17 ~~(4)~~

18 (3) The person is covered for similar benefits by an individual  
19 policy or contract.

20 ~~(5)~~

21 (4) The person has not been continuously covered during the  
22 three-month period immediately preceding that person's  
23 termination of coverage.

24 (d) Benefits of a conversion contract shall meet the  
25 requirements for benefits under this chapter.

26 (e) Unless waived in writing by the plan, written application  
27 and first premium payment for the conversion contract shall be  
28 made not later than ~~34~~ 63 days after termination from the group.

29 (f) The conversion contract shall cover the employee or  
30 member and his or her dependents who were covered under the  
31 group contract on the date of their termination from the group.

32 (g) A notification of the availability of the conversion coverage  
33 shall be included in each evidence of coverage. However, it shall  
34 be the sole responsibility of the employer to notify its employees  
35 of the availability, terms, and conditions of the conversion  
36 coverage which responsibility shall be satisfied by notification  
37 within 15 days of termination of group coverage. Group coverage  
38 shall not be deemed terminated until the expiration of any  
39 continuation of the group coverage. For purposes of this  
40 subdivision, the employer shall not be deemed the agent of the plan

for purposes of notification of the availability, terms, and conditions of conversion coverage.

(h) ~~As used in this section, “hospital, medical, or surgical benefits under state or federal law” do not include benefits under Chapter 7 (commencing with Section 14000) or Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code, or Title XIX of the United States Social Security Act. This section shall become inoperative on March 31, 2003, and, as of January 1, 2004, is repealed, unless a later enacted statute, that becomes operative on or before January 1, 2004, deletes or extends the dates on which it becomes inoperative and is repealed.~~

SEC. 6. Section 1373.6 is added to the Health and Safety Code, to read:

1373.6. This section does not apply to a specialized health care service plan contract or to a plan contract that primarily or solely supplements Medicare. The director may adopt rules consistent with federal law to govern the discontinuance and replacement of plan contracts that primarily or solely supplement Medicare.

(a) (1) Every group contract entered into, amended or renewed on or after March 31, 2003, that provides hospital, medical, or surgical expense benefits for employees or members shall provide that an employee or member whose coverage under the group contract has been terminated by the employer shall be entitled to convert to nongroup membership, without evidence of insurability, subject to the terms and conditions of this section.

(2) If the health care service plan provides coverage under an individual health care service plan contract, it shall offer the same coverage that it is required to offer to a federally eligible defined individual pursuant to Section 1366.35. The plan shall provide this coverage at the same rate established under Section 1399.805 for a federally eligible defined individual. A health care service plan that is federally qualified under the federal Health Maintenance Organization Act (42 U.S.C. Sec. 300e et seq.) may charge a rate for the coverage that is consistent with the provisions of that act.

(3) If the health care service plan does not provide coverage under an individual health care service plan contract, it shall offer a health benefit plan contract that is the same as a health benefit contract offered to a federally eligible defined individual pursuant

1 to Section 1366.35 by a health care service plan that provides  
2 coverage under an individual health care service plan contract.  
3 The health care service plan may offer either of the two health  
4 benefit plan contracts that have the greatest number of enrolled  
5 individuals as of January 1 of the prior year, as reported by plans  
6 that provide coverage under an individual health care service plan  
7 contract. The health care service plan shall provide this coverage  
8 with the same cost-sharing terms and at the same premium as a  
9 health care service plan providing coverage to that individual  
10 under an individual health care service plan contract. The health  
11 care service plan shall file the health benefit plans it will offer,  
12 including the premium it will charge and the cost-sharing terms of  
13 the plan, with the Department of Managed Health Care.

14 (b) A conversion contract shall not be required to be made  
15 available to an employee or member if termination of his or her  
16 coverage under the group contract occurred for any of the  
17 following reasons:

18 (1) The group contract terminated or an employer's  
19 participation terminated.

20 (2) The employee or member failed to pay amounts due the  
21 health care service plan.

22 (3) The employee or member was terminated by the health care  
23 service plan from the plan for good cause.

24 (4) The employee or member knowingly furnished incorrect  
25 information or otherwise improperly obtained the benefits of the  
26 plan.

27 (5) The employer's hospital, medical, or surgical expense  
28 benefit program is self-insured.

29 (c) A conversion contract is not required to be issued to any  
30 person if any of the following facts are present:

31 (1) The person is covered by or is eligible for benefits under  
32 Title XVIII of the United States Social Security Act.

33 (2) The person is covered by or is eligible for hospital, medical,  
34 or surgical benefits under state or federal law. As used in this  
35 paragraph, "hospital, medical, or surgical benefits under state or  
36 federal law" do not include benefits under Chapter 7  
37 (commencing with Section 14000) or Chapter 8 (commencing with  
38 Section 14200) of Part 3 of Division 9 of the Welfare and  
39 Institutions Code, or Title XIX of the United States Social Security  
40 Act.

1     (3) *The person is covered by or is eligible for hospital, medical,*  
2 *or surgical benefits under any arrangement of coverage for*  
3 *individuals in a group, whether insured or self-insured.*

4     (4) *The person is covered for similar benefits by an individual*  
5 *policy or contract.*

6     (5) *The person has not been continuously covered during the*  
7 *three-month period immediately preceding that person's*  
8 *termination of coverage.*

9     (d) *Benefits of a conversion contract shall meet the*  
10 *requirements for benefits under this chapter.*

11     (e) *Unless waived in writing by the plan, written application*  
12 *and first premium payment for the conversion contract shall be*  
13 *made not later than 31 days after termination from the group.*

14     (f) *The conversion contract shall cover the employee or*  
15 *member and his or her dependents who were covered under the*  
16 *group contract on the date of their termination from the group.*

17     (g) *A notification of the availability of the conversion coverage*  
18 *shall be included in each evidence of coverage. The health care*  
19 *service plan shall provide the employer with the comparative*  
20 *benefit matrix prepared pursuant to Section 1348.5. However, it*  
21 *shall be the sole responsibility of the employer to notify its*  
22 *employees of the availability, terms, and conditions of the*  
23 *conversion coverage which responsibility shall be satisfied by*  
24 *notification within 15 days of termination of group coverage. It*  
25 *shall also be the sole responsibility of the employer to distribute the*  
26 *comparative benefit matrix with this notice. Group coverage shall*  
27 *not be deemed terminated until the expiration of any continuation*  
28 *of the group coverage. For purposes of this subdivision, the*  
29 *employer shall not be deemed the agent of the plan for purposes*  
30 *of notification of the availability, terms, and conditions of*  
31 *conversion coverage.*

32     (h) *At least 20 business days prior to renewing or amending a*  
33 *plan contract subject to this section, or at least 20 business days*  
34 *prior to the initial offering of a plan contract subject to this section,*  
35 *a plan shall file a notice of an amendment with the director in*  
36 *accordance with the provisions of Section 1352. The notice of an*  
37 *amendment shall include a statement certifying that the plan is in*  
38 *compliance with this section. Any action by the director, as*  
39 *permitted under Section 1352, to disapprove, suspend, or postpone*  
40 *the health care service plan's use of a plan contract shall be in*

1 writing, specifying the reasons the plan contract does not comply  
2 with the requirements of this section. Prior to making any changes  
3 in the premium, the health care service plan shall file an  
4 amendment in accordance with the provisions of Section 1352, and  
5 shall include a statement certifying the plan is in compliance with  
6 subdivision (a). All other changes to a plan contract that was  
7 previously filed with the director shall be filed as an amendment  
8 in accordance with the provisions of Section 1352, unless the  
9 change otherwise would require the filing of a material  
10 modification.

11 (i) This section shall become operative on March 31, 2003.

12 SEC. 7. Section 1373.62 is added to the Health and Safety  
13 Code, to read:

14 1373.62. (a) This section shall apply only to a health care  
15 service plan offering hospital, medical, or surgical benefits in the  
16 individual market in California and shall not apply to a specialized  
17 health care service plan, a health care service plan contract in the  
18 Medi-Cal program (Chapter 7 (commencing with Section 14000)  
19 of Part 3 of Division 9 of the Welfare and Institutions Code), or a  
20 health care service plan contract in the Healthy Families Program  
21 (Part 6.2 (commencing with Section 12693) of Division 2 of the  
22 Insurance Code).

23 (b) For the purposes of this section, "program" means the  
24 California Major Risk Medical Insurance Program (Part 6.5  
25 (commencing with Section 12700) of Division 2 of the Insurance  
26 Code).

27 (c) (1) Each health care service plan subject to this section  
28 shall offer at least one standard benefit plan. The calendar year  
29 limit on benefits under the plan shall be at least two hundred  
30 thousand dollars (\$200,000), and the lifetime maximum benefit  
31 under the plan shall be at least seven hundred fifty thousand  
32 dollars (\$750,000). No health care service plan is required to  
33 provide calendar year benefits or a lifetime maximum benefit  
34 under the plan that exceed these limits, however. In calculating the  
35 calendar year and lifetime maximum benefits for any person  
36 receiving coverage through a standard benefit plan, the health  
37 care service plan shall not include any health care benefits or  
38 services that person received while enrolled in the program.

39 (2) The standard benefit plan of a health care service plan  
40 participating in the program shall be the same benefit design it

1 offers through the program. If the health care service plan offers  
2 more than one benefit design in the program, it shall offer only one  
3 of those benefit designs as its standard benefit plan.

4 (3) (A) The standard benefit plan of a health care service plan  
5 that is not a participating health plan within the program shall be  
6 any one benefit design that is offered through the program by a  
7 health care service plan participating in the program.

8 (B) A health care service plan that is not a participating health  
9 plan in the program that is under common ownership with, is  
10 affiliated with, or files consolidated income tax returns with, a  
11 health insurer that is also an insurer in the individual market may  
12 satisfy the requirements of this section and Section 10127.15 of the  
13 Insurance Code by offering one standard benefit plan.

14 (C) A health care service plan that is not a participating health  
15 plan in the program that is under common ownership with, is  
16 affiliated with, or files consolidated income tax returns with, a  
17 health insurer that is in the individual market and that is a  
18 participating health plan in the program is exempt from the  
19 provisions of this section, if the insurer meets the requirements of  
20 Section 10127.15 of the Insurance Code.

21 (d) A health care service plan may not reject an application for  
22 coverage under its standard benefit plan for an individual who  
23 applies for coverage within 63 days of the termination date of his  
24 or her previous coverage, if the individual has had continuous  
25 coverage under the program for a period of 36 consecutive months.

26 (e) The amount paid by a subscriber for the standard benefit  
27 plan shall be 110 percent of the contribution the subscriber would  
28 pay in the program for the benefit design providing the same  
29 coverage, using the same methodology in effect on July 1, 2002,  
30 for calculating the rates in the program. If a health care service  
31 plan offers calendar year and lifetime maximum benefits in its  
32 standard benefit plan that exceed those in the benefit design  
33 offered through the program, it may not increase the amount paid  
34 by the subscriber for the standard benefit plan.

35 (f) (1) At least 20 business days prior to renewing or amending  
36 a plan contract subject to this section, or at least 20 business days  
37 prior to the initial offering of a plan contract subject to this section,  
38 a health care service plan shall file a notice of an amendment with  
39 the director in accordance with the provisions of Section 1352. The  
40 notice of an amendment shall include a statement certifying that

1 *the health care service plan is in compliance with this section. Any*  
2 *action by the director, as allowed under Section 1352, to*  
3 *disapprove, suspend, or postpone the health care service plan's use*  
4 *of a plan contract shall be in writing, specifying the reasons the*  
5 *plan contract does not comply with the requirements of this*  
6 *section.*

7 (2) *Prior to making any changes in the premium charged for its*  
8 *standard benefit plan, the health care service plan shall file an*  
9 *amendment in accordance with the provisions of Section 1352 and*  
10 *shall include a statement certifying the plan is in compliance with*  
11 *subdivision (e).*

12 (3) *All other changes to a plan contract that was previously*  
13 *filed with the director shall be filed as an amendment in*  
14 *accordance with the provisions of Section 1352, unless the change*  
15 *otherwise would require the filing of a material modification.*

16 (g) (1) *Each health care service plan shall report to the*  
17 *Managed Risk Medical Insurance Board the amount it has*  
18 *expended for health care services for individuals covered under a*  
19 *standard benefit plan under this section and the total amount of*  
20 *subscriber payments it has charged individuals for the standard*  
21 *benefit plan. The board shall establish by regulation the format for*  
22 *these reports. The report shall be prepared for each of the*  
23 *following reporting periods and shall be submitted within 12*  
24 *months of the final date of the reporting period:*

25 (A) *July 1, 2003, to December 31, 2003, inclusive.*

26 (B) *January 1, 2004, to December 31, 2004, inclusive.*

27 (C) *January 1, 2005, to December 31, 2005, inclusive.*

28 (D) *January 1, 2006, to December 31, 2006, inclusive.*

29 (E) *January 1, 2007, to June 30, 2007, inclusive.*

30 (2) *"Health care services" means the aggregate health care*  
31 *expenses paid by the health care service plan during the reporting*  
32 *period plus the aggregate value of the standard monthly*  
33 *administrative fee. Health care expenses do not include costs that*  
34 *have been incurred but not reported by the health care service*  
35 *plan. The calculation of health care expenses shall be consistent*  
36 *with the methodology used on July 1, 2002, to calculate such*  
37 *expenses for participating health plans in the program. The*  
38 *"standard monthly administrative fee" is the average monthly, per*  
39 *person administrative fee paid by the program to participating*  
40 *health plans during the reporting period.*

1 (3) The “total amount of subscriber payments” is the  
2 aggregate of the monthly subscriber payments charged by the  
3 health care service plan during the reporting period. The  
4 calculation of the total amount of subscriber payments charged  
5 shall be consistent with the methodology used on July 1, 2002, to  
6 calculate subscriber contributions in the program. The Managed  
7 Risk Medical Insurance Board shall by regulation establish the  
8 format for submitting documentation of the subscriber payments.

9 (4) The Managed Risk Medical Insurance Board may verify the  
10 health care expenses incurred by a health care service plan and the  
11 subscriber payments received by the plan. The verification shall  
12 include assurance that the subscriber was enrolled in the standard  
13 benefit plan during the reporting period in which the health care  
14 service plan paid health care expenses on the subscriber’s behalf,  
15 and that the expenses reported are consistent with the standard  
16 benefit plan.

17 (h) (1) The program shall pay each health care service plan an  
18 amount that is equal to one-half of the difference between the  
19 amount the health care service plan expended for health care  
20 services for individuals covered under a standard benefit plan and  
21 the total amount of subscriber payments charged to those  
22 individuals who have had continuous coverage under the program  
23 for a period of 36 consecutive months. The program shall make this  
24 payment from the Major Risk Medical Insurance Fund or from any  
25 funds appropriated in the annual Budget Act or by another statute  
26 to the program for the purposes of this section. The state shall not  
27 be liable for any amount in excess of the moneys in the Major Risk  
28 Medical Insurance Fund or other funds that were appropriated for  
29 the purposes of this section. If the state fails to appropriate  
30 sufficient funds for the state’s contribution amount to any health  
31 care service plan, the health care service plan may increase the  
32 monthly payments that its subscribers are required to pay for any  
33 standard benefit plan to the amount that the Managed Risk  
34 Medical Insurance Board would charge without a state subsidy for  
35 the same plan issued to the same individual within the program.

36 (2) The Managed Risk Medical Insurance Board shall make a  
37 biannual, interim payment to each health care service plan  
38 providing coverage pursuant to this section. For the first two  
39 reporting periods described in this section, biannual interim  
40 payments shall be calculated for each subscriber as the product of

1 the average premium in the program for that reporting period and  
2 one-half of the difference between the program's prior calendar  
3 year loss ratio and 110 percent. For subsequent reporting periods,  
4 the Managed Risk Medical Insurance Board may, by regulation,  
5 adopt for each health care service plan, a specific method for  
6 calculating biannual interim payments based on the plan's actual  
7 experience in providing the benefits described in this section. Each  
8 health care service plan shall submit a six-month interim report of  
9 subscriber enrollment in its standard benefit plan. The Managed  
10 Risk Medical Insurance Board shall make an interim payment to  
11 each health care service plan pursuant to this section no later than  
12 45 days after the receipt of the plan's enrollment reports. Final  
13 payment by the board or refund from the health care service plan  
14 shall be made upon the completion of verification activities  
15 conducted pursuant to this section.

16 (i) (1) The provisions of this section constitute a pilot program.  
17 After the provisions of this section become inoperative on July 1,  
18 2007, as specified in subdivision (j), the pilot program shall  
19 terminate.

20 (2) After the termination of the pilot program, a health care  
21 service plan shall continue to provide coverage under the same  
22 terms and conditions specified in this section, including the terms  
23 of the standard benefit plan and the subscriber payment amount,  
24 to each individual who enrolled during the term of the pilot  
25 program, and the Managed Risk Medical Insurance Board shall  
26 continue to pay the amount described in this section for each of  
27 those individuals. A health care service plan shall not be required  
28 to offer the coverage described in this section after the termination  
29 of the pilot program.

30 (j) This section shall become operative on March 31, 2003, and  
31 shall become inoperative on July 1, 2007. As of January 1, 2008,  
32 this section is repealed, unless a later enacted statute, that  
33 becomes operative on or before January 1, 2008, deletes or  
34 extends the dates on which this section becomes inoperative and  
35 is repealed.

36 SEC. 8. Section 10113.8 is added to the Insurance Code, to  
37 read:

38 10113.8. (a) Each health insurer that maintains an Internet  
39 Web site shall make a downloadable copy of the comparative  
40 benefit matrix prepared pursuant to Section 10127.14 available

1 *through its site and ensure that the most current update of the*  
2 *matrix is available on its site.*

3 *(b) Each health insurer shall send copies of the comparative*  
4 *benefit matrix on an annual basis, or more frequently as the matrix*  
5 *is updated by the department and the Department of Managed*  
6 *Health Care, to solicitors and solicitor firms and employers with*  
7 *whom it contracts. Each health insurer shall require its*  
8 *representatives and the solicitors and soliciting firms with which*  
9 *it contracts, to provide a copy of the comparative benefit matrix to*  
10 *individuals when presenting any benefit package for examination*  
11 *or sale.*

12 *SEC. 9. Section 10127.14 is added to the Insurance Code, to*  
13 *read:*

14 *10127.14. (a) The department and the Department of*  
15 *Managed Health Care shall compile information required by this*  
16 *section and Section 1348.5 of the Health and Safety Code into two*  
17 *comparative benefit matrices. The first matrix shall compare*  
18 *benefit packages offered pursuant to Section 1373.62 of the Health*  
19 *and Safety Code and Section 10127.15. The second matrix shall*  
20 *compare benefit packages offered pursuant to Sections 1366.35,*  
21 *1373.6, and 1399.804 of the Health and Safety Code and Sections*  
22 *10785, 12682.5, 12683, and 12684.*

23 *(b) The comparative benefit matrix shall include:*

24 *(1) Benefit information submitted by health care service plans*  
25 *pursuant to Section 1348.5 of the Health and Safety Code and by*  
26 *health insurers pursuant to subdivision (d).*

27 *(2) The following statements in at least 12-point type at the top*  
28 *of the matrix:*

29 *(A) "This matrix is intended to help you compare coverage and*  
30 *benefits and is a summary only. For a more detailed description of*  
31 *coverage, benefits, and limitations, please contact the health care*  
32 *service plan or health insurer."*

33 *(B) "The comparative benefit matrix is updated annually, or*  
34 *more often if necessary to be accurate."*

35 *(C) "If the health care service plan or health insurer maintains*  
36 *an Internet Web site, the most current version of this comparative*  
37 *benefit matrix is available on its site at (address of the plan's or*  
38 *insurer's site)."*

1     (3) *The telephone number or numbers that may be used by an*  
2 *applicant to contact either the department or the Department of*  
3 *Managed Health Care, as appropriate, for further assistance.*

4     (c) *The department and the Department of Managed Health*  
5 *Care shall jointly prepare two standardized templates for use by*  
6 *health care service plans and health insurers in submitting the*  
7 *information required pursuant to subdivision (d) of Section 1348.5*  
8 *and subdivision (d). The template shall be exempt from the*  
9 *provisions of Chapter 3.5 (commencing with Section 11340) of*  
10 *Part 1 of Division 3 of Title 2 of the Government Code.*

11     (d) *Health insurers shall submit the following to the*  
12 *department:*

13     (1) *A summary explanation of the following for each product*  
14 *described in subdivision (a):*

15     (A) *Eligibility requirements.*

16     (B) *The full premium cost of each benefit package in the service*  
17 *area in which the individual and eligible dependents work or*  
18 *reside.*

19     (C) *When and under what circumstances benefits cease.*

20     (D) *The terms under which coverage may be renewed.*

21     (E) *Other coverage that may be available if benefits under the*  
22 *described benefit package cease.*

23     (F) *The circumstances under which choice in the selection of*  
24 *physicians and providers is permitted.*

25     (G) *Lifetime and annual maximums.*

26     (H) *Deductibles.*

27     (2) *A summary explanation of the following coverages,*  
28 *together with the corresponding copayments and limitations, for*  
29 *each product described in subdivision (a):*

30     (A) *Professional services.*

31     (B) *Outpatient services.*

32     (C) *Hospitalization services.*

33     (D) *Emergency health coverage.*

34     (E) *Ambulance services.*

35     (F) *Prescription drug coverage.*

36     (G) *Durable medical equipment.*

37     (H) *Mental health services.*

38     (I) *Residential treatment.*

39     (J) *Chemical dependency services.*

40     (K) *Home health services.*

1     (L) Custodial care and skilled nursing facilities.

2     (3) The telephone number or numbers that may be used by an  
3     applicant to access a health insurer customer service  
4     representative and to request additional information about the  
5     plan contract.

6     (4) Any other information specified by the department in the  
7     template.

8     (e) Each health insurer shall provide the department with  
9     updates to the information required by subdivision (d) at least  
10    annually, or more often if necessary to maintain the accuracy of the  
11    information.

12    (f) The department and the Department of Managed Health  
13    Care shall make the comparative benefit matrices available on  
14    their respective Internet Web sites and to the health care service  
15    plans and health insurers for dissemination as required by Section  
16    1373.6 of the Health and Safety Code and Section 12689.

17    SEC. 10. Section 10127.15 is added to the Insurance Code, to  
18    read:

19    10127.15. (a) This section shall apply only to a health insurer  
20    offering hospital, medical, or surgical benefits in the individual  
21    market in California and shall not apply to accident-only,  
22    specified disease, long-term care, hospital indemnity, Medicare  
23    supplement, dental-only, or vision-only insurance policies.

24    (b) For the purposes of this section, "program" means the  
25    California Major Risk Medical Insurance Program (Part 6.5  
26    (commencing with Section 12700)).

27    (c) (1) Each health insurer subject to this section shall offer  
28    one standard benefit plan. The calendar year limit on benefits  
29    under the plan shall be at least two hundred thousand dollars  
30    (\$200,000), and the lifetime maximum benefit under the plan shall  
31    be at least seven hundred fifty thousand dollars (\$750,000). No  
32    health insurer is required to provide calendar year benefits or a  
33    lifetime maximum benefit under the plan that exceed these limits,  
34    however. In calculating the calendar year and lifetime maximum  
35    benefits for any person receiving coverage through a standard  
36    benefit plan, the health insurer shall not include any health  
37    benefits or services that person received while enrolled in the  
38    program.

39    (2) The standard benefit plan of a health insurer participating  
40    in the program shall be the same benefit design if offers through

1 *the program. If the health insurer offers more than one benefit*  
2 *design in the program, it shall offer only one of those benefit*  
3 *designs as its standard benefit plan.*

4 (3) (A) *The standard benefit plan of a health insurer that is not*  
5 *a participating health plan within the program shall be any one*  
6 *benefit design that is offered through the program.*

7 (B) *A health insurer that is not a participating health plan*  
8 *within the program that is under common ownership with, is*  
9 *affiliated with, or files consolidated income tax returns with, a*  
10 *health care service plan that is in the individual market, may*  
11 *satisfy the requirements of this section and Section 1373.62 of the*  
12 *Health and Safety Code by offering one standard benefit plan.*

13 (C) *A health insurer that is not a participating health plan in*  
14 *the program that is under common ownership with, is affiliated*  
15 *with, or files consolidated income tax returns with a health care*  
16 *service plan that is in the individual market and that is a*  
17 *participating health plan in the program is exempt from the*  
18 *provisions of this section, if the plan meets the requirements of*  
19 *Section 1373.62 of the Health and Safety Code.*

20 (d) *A health insurer may not reject an application for coverage*  
21 *under its standard benefit plan for an individual who applies for*  
22 *coverage within 63 days of the termination date of his or her*  
23 *previous coverage, if the individual has had continuous coverage*  
24 *under the program for a period of 36 consecutive months.*

25 (e) *The amount paid by a subscriber for the standard benefit*  
26 *plan shall be 110 percent of the contribution the subscriber would*  
27 *pay in the program for the benefit design providing the same*  
28 *coverage, using the same methodology in effect on July 1, 2002,*  
29 *for calculating the rates in the program. If a health insurer offers*  
30 *calendar year and lifetime maximum benefits in its standard*  
31 *benefit plan that exceed those in the benefit design offered through*  
32 *the program, it may not increase the amount paid by the subscriber*  
33 *for the standard benefit plan. To ensure compliance with this*  
34 *requirement, the department shall, in consultation with the*  
35 *Managed Risk Medical Insurance Board, review and confirm the*  
36 *amount of the subscriber payments charged by a health insurer for*  
37 *a standard benefit plan.*

38 (f) (1) *Each health insurer shall report to the Managed Risk*  
39 *Medical Insurance Board the amount it has expended for health*  
40 *care services for individuals covered under a standard benefit plan*

under this section and the total amount of subscriber payments it has charged individuals for the standard benefit plan. The board shall establish by regulation the format for these reports. The report shall be prepared for each of the following reporting periods and shall be submitted within 12 months of the final date of the reporting period:

(A) July 1, 2003, to December 31, 2003, inclusive.

(B) January 1, 2004, to December 31, 2004, inclusive.

(C) January 1, 2005, to December 31, 2005, inclusive.

(D) January 1, 2006, to December 31, 2006, inclusive.

(E) January 1, 2007, to June 30, 2007, inclusive.

(2) "Health care services" means the aggregate health care expenses paid by the health insurer during the reporting period plus the aggregate value of the standard monthly administrative fee. Health care expenses do not include costs that have been incurred but not reported by the health insurer. The calculation of health care expenses shall be consistent with the methodology used on July 1, 2002, to calculate such expenses for participating health plans in the program. The "standard monthly administrative fee" is the average monthly, per person administrative fee paid by the program to participating health plans during the reporting period.

(3) The "total amount of subscriber payments" is the aggregate of the monthly subscriber payments charged by the health insurer during the reporting period. The calculation of the total amount of subscriber payments charged shall be consistent with the methodology used on July 1, 2002, to calculate subscriber contributions in the program. The Managed Risk Medical Insurance Board shall by regulation establish the format for submitting documentation of subscriber payments.

(4) The Managed Risk Medical Insurance Board may verify the health care expenses incurred by a health insurer and the subscriber payments received by the insurer. The verification shall include assurance that the subscriber was enrolled in the standard benefit plan during the reporting period in which the health insurer paid health care expenses on the subscriber's behalf, and that the expenses reported are consistent with the standard benefit plan.

(g) (1) The program shall pay each health insurer an amount that is equal to one-half of the difference between the amount the health insurer expended for health care services for individuals covered under a standard benefit plan and the total amount of

1 subscriber payments charged to those individuals who have had  
2 continuous coverage under the program for a period of 36  
3 consecutive months. The program shall make this payment from  
4 the Major Risk Medical Insurance Fund or from any funds  
5 appropriated in the annual Budget Act or by another statute to the  
6 program for the purposes of this section. The state shall not be  
7 liable for any amount in excess of the Major Risk Medical  
8 Insurance Fund or other funds that were appropriated for the  
9 purposes of this section. If the state fails to appropriate sufficient  
10 funds for the state's contribution amount to any health insurer, the  
11 health insurer may increase the monthly payments that its  
12 subscribers are required to pay for any standard benefit plan to the  
13 amount that the Managed Risk Medical Insurance Board would  
14 charge without a state subsidy for the same plan issued to the same  
15 individual within the program.

16 (2) The Managed Risk Medical Insurance Board shall make a  
17 biannual, interim payment to each health insurer providing  
18 coverage pursuant to this section. For the first two reporting  
19 periods described in this section, biannual interim payments shall  
20 be calculated for each subscriber as the product of the average  
21 premium in the program for that reporting period and one-half of  
22 the difference between the program's prior calendar year loss ratio  
23 and 110 percent. For subsequent reporting periods, the Managed  
24 Risk Medical Insurance Board may, by regulation, adopt for each  
25 health insurer, a specific method for calculating biannual interim  
26 payments based on the insurer's actual experience in providing the  
27 benefits described in this section. Each health insurer shall submit  
28 a six-month interim report of enrollment in its standard benefit  
29 plan. The Managed Risk Medical Insurance Board shall make an  
30 interim payment to each health insurer pursuant to this section no  
31 later than 45 days after receipt of the insurer's enrollment reports.  
32 Final payment by the board or refund from the insurer shall be  
33 made upon the completion of verification activities conducted  
34 pursuant to this section.

35 (h) (1) The provisions of this section constitute a pilot  
36 program. After the provisions of this section become inoperative  
37 on July 1, 2007, as specified in subdivision (i), the pilot program  
38 shall terminate.

39 (2) After the termination of the pilot program, a health insurer  
40 shall continue to provide coverage under the same terms and

conditions specified in this section, including the terms of the standard benefit plan and the subscriber payment amount, to each individual who enrolled during the term of the pilot program; and the Managed Risk Medical Insurance Board shall continue to pay the amount described in this section for each of those individuals.

A health insurer shall not be required to offer the coverage described in this section after the termination of the pilot program.

(i) This section shall become operative on March 31, 2003, and shall become inoperative on July 1, 2007. As of January 1, 2008, this section is repealed, unless a later enacted statute, that becomes operative on or before January 1, 2008, deletes or extends the date on which the section becomes inoperative and is repealed.

SEC. 11. Section 10128.59 is added to the Insurance Code, to read:

10128.59. (a) A health insurer that provides coverage under a group benefit plan to an employer shall offer an individual who has exhausted continuation coverage under COBRA or Cal-COBRA, the opportunity to continue coverage for up to 36 months from the date the individual's continuation coverage began, if the individual is entitled to less than 36 months of continuation coverage under COBRA or Cal-COBRA. The health insurer shall offer coverage pursuant to terms of this article.

(b) Notification of the coverage available under this section shall be included in the notice of the pending termination of COBRA coverage that is required to be provided to COBRA beneficiaries and that is required to be provided under Section 10128.54. In addition, each health insurer shall disclose as part of its COBRA or Cal-COBRA disclosure and enrollment documents, an explanation of the availability of guaranteed access to coverage under the Health Insurance Portability and Accountability Act of 1996, including the necessity to enroll in and exhaust COBRA or Cal-COBRA benefits in order to become a federally eligible defined individual. Each health insurer shall also disclose to qualified individuals the availability of continuation coverage beyond the maximum term provided under COBRA and Cal-COBRA.

(c) In computing the amount of the premium charged to any specific employer group, the health insurer shall not consider the

1 *specific medical expenditures for beneficiaries receiving*  
2 *continuation coverage pursuant to this section.*

3 *(d) For purposes of this section, "COBRA" means Section*  
4 *4980B of Title 26 of the United States Code, Sections 1161 et seq.*  
5 *of Title 29 of the United States Code, and Section 300bb of Title 42*  
6 *of the United States Code.*

7 *(e) This section shall not apply to accident-only, specified*  
8 *disease, hospital indemnity, long-term care, Medicare*  
9 *supplement, dental-only, or vision-only insurance policies.*

10 *(f) This section shall become operative on March 31, 2003.*

11 *SEC. 12. Section 12678 of the Insurance Code is amended to*  
12 *read:*

13 12678. The insurer shall not be required to issue a converted  
14 policy covering any person if any of the following exists:

15 (a) ~~Such~~ The person is covered for similar benefits by another  
16 individual policy.

17 (b) ~~Such~~ The person is covered or is eligible to be covered for  
18 similar benefits by another group policy.

19 (c) ~~Such~~ The person is covered or is eligible to be covered for  
20 similar benefits under any arrangement of coverage for persons in  
21 a group whether insured or uninsured.

22 (d) ~~Similar benefits are provided for or are available to such~~  
23 ~~person, by reason of any state or federal law.~~

24 (e) ~~As used in this section, "state or federal law" does not~~  
25 ~~include Chapter 7 (commencing with Section 14000) of Chapter~~  
26 ~~8 (commencing with Section 14200) of Part 3 of Division 9 of the~~  
27 ~~Welfare and Institutions Code, or Title XIX of the United States~~  
28 ~~Social Security Act.~~

29 *SEC. 13. Section 12682 of the Insurance Code is amended to*  
30 *read:*

31 12682. (a) The converted policy shall not exclude, as a  
32 preexisting condition, any condition covered by the group policy.  
33 The converted policy may provide for a reduction of its benefits  
34 by the amount of ~~any such~~ the benefits payable under the group  
35 policy after the individual's insurance terminates ~~thereunder~~  
36 *under the policy.* The converted policy may also provide that  
37 during the first policy year the benefits payable under the  
38 converted policy, together with the benefits payable under the  
39 group policy, shall not exceed those that would have been payable

1 had the individual's coverage under the group policy remained in  
2 effect.

3 *(b) This section shall become inoperative on March 31 2003,*  
4 *and, as of January 1, 2004, is repealed, unless a later enacted*  
5 *statute, that because operative on or before January 1, 2004,*  
6 *deletes or extends the dates on which the section becomes*  
7 *inoperative and is repealed.*

8 SEC. 14. Section 12682.5 is added to the Insurance Code, to  
9 read:

10 12682.5. (a) Subject to the provisions and conditions of this  
11 part, if the group policy from which conversion is made provides  
12 the employee or member with insurance, the employee or member  
13 shall be entitled to obtain a converted policy providing  
14 comprehensive medical coverage providing, at minimum, the same  
15 coverage that is required to be offered to a federally eligible  
16 individual pursuant to Section 10785 at the same rate applicable  
17 to that coverage pursuant to Section 10901.3. If the health insurer  
18 does not participate in the individual market, the insurer shall offer  
19 a converted policy that is the same as a health benefit plan offered  
20 to a federally eligible defined individual by a health insurer in the  
21 individual market pursuant to Section 10901.3. The health insurer  
22 may offer either of the two most popular policies offered to  
23 federally eligible defined individuals based on premium volumes  
24 as of January 1 of the previous year, reported to the department by  
25 insurers in the individual market. The health insurer shall charge  
26 the individual the same rate with the same cost-sharing terms that  
27 it would charge in the individual market for that plan covering the  
28 individual. Health insurers shall file the converted policy it will  
29 offer pursuant to this section with the department for approval.

30 (b) Notwithstanding subdivision (a), any individual enrolled in  
31 conversion coverage on or before March 31, 2003, shall continue  
32 to be enrolled in that coverage and pay monthly premiums  
33 according to the requirements of this article that were applicable  
34 at the time of the individual's enrollment.

35 (c) This section shall become operative on March 31, 2003.

36 SEC. 15. Section 12683 of the Insurance Code is amended to  
37 read:

38 12683. Subject to the provisions and conditions of this part,  
39 if the group policy from which conversion is made covers the  
40 employee or member for basic hospital or surgical expense, the

1 employee or member shall be entitled to obtain a converted policy  
2 providing at least the following minimum benefits:

3 (a) Plan A.

4 (1) Hospital room and board daily expense benefits up to two  
5 hundred dollars (\$200) for a duration of 70 days.

6 (2) Miscellaneous hospital expense benefits up to an amount of  
7 10 times the hospital room and board daily expense benefits.

8 (3) Surgical expense benefits according to a surgical  
9 procedures schedule consistent with those customarily offered by  
10 the insurer under a group or individual health insurance policy and  
11 providing a maximum benefit of four thousand eight hundred  
12 dollars (\$4,800).

13 (b) Plan B—75 percent of the dollar amounts of Plan A.

14 (c) Plan C—50 percent of the dollar amounts of Plan A.

15 (d) The maximum dollar amount for Plan A's hospital room and  
16 board daily expense and surgical benefit may be redetermined by  
17 the Insurance Commissioner as to conversion coverage issued  
18 subsequent to that redetermination. The redetermination shall not  
19 be made more often than once in three years. The maximum dollar  
20 amount redetermined by the commissioner for hospital room and  
21 board shall not exceed 80 percent of the average semiprivate room  
22 rate then charged in the state.

23 (e) Covered expenses under this section shall include benefits  
24 for expense incurred by the employee, member, or spouse in  
25 connection with pregnancy, provided that:

26 (1) The pregnancy commenced while covered under the group  
27 policy from which conversion was made.

28 (2) The expense is of a type which would have been covered  
29 under such group policy.

30 (3) The conversion policy is in force when the expense is  
31 incurred.

32 (f) *This section shall become inoperative on March 31, 2003,*  
33 *and, as of January 1, 2004, is repealed, unless a later enacted*  
34 *statute, that becomes operative on or before January 1, 2004,*  
35 *deletes or extends the dates on which it becomes inoperative and*  
36 *is repealed.*

37 SEC. 16. Section 12684 of the Insurance Code is amended to  
38 read:

39 12684. Subject to the provisions and conditions of this part,  
40 if the group policy from which conversion is made provides the

1 employee or member with major medical or comprehensive  
2 medical insurance, the employee or member shall be entitled to  
3 obtain a converted policy providing comprehensive medical  
4 coverage providing at least the following benefits:

5 (a) A payment per covered person for all covered medical  
6 expenses incurred during the person's lifetime equal to one  
7 hundred thousand dollars (\$100,000); provided, however, that for  
8 treatment of mental illness payment may be limited to ten thousand  
9 dollars (\$10,000) during the person's lifetime.

10 (b) Payment of benefits at the rate of 75 percent of covered  
11 medical expenses; provided, however, that if coverage is provided  
12 for expenses incurred for outpatient treatment of mental illness,  
13 payment of benefits may be at the rate of 50 percent of such  
14 covered expenses, and the insurer may limit the amount of covered  
15 expense for each outpatient visit and the amount of benefits  
16 payable for expenses incurred during each calendar year for that  
17 outpatient treatment.

18 (c) A cash deductible for each benefit period at the option of the  
19 insured of two hundred dollars (\$200), five hundred dollars  
20 (\$500), or one thousand dollars (\$1,000), but not less than the cash  
21 deductible which applied to the insured under the group policy  
22 which entitles him or her to a converted policy.

23 (d) Covered medical expenses shall include the charges for a  
24 semiprivate hospital room and board, but need not exceed the  
25 lesser of two hundred dollars (\$200) per day or the hospital's most  
26 common charge for a semiprivate room, covered expenses for  
27 intensive care shall be at least two and one-half times the covered  
28 hospital room and board charge. The maximum dollar amount for  
29 hospital room and board daily covered expense may be  
30 redetermined by the commissioner as to conversion coverage  
31 issued after the redetermination. That redetermination shall not be  
32 made more often than once in three years. The maximum dollar  
33 amount redetermined by the commissioner shall not exceed the  
34 average semiprivate room rate then charged in the state.

35 (e) Covered expenses under this section shall include benefits  
36 for expense incurred by the employee, member, or spouse in  
37 connection with pregnancy, provided that:

38 (1) The pregnancy commenced while covered under the group  
39 policy from which conversion was made.

1 (2) The expense is of a type which would have been covered  
2 under such group policy.

3 (3) The conversion policy is in force when the expense is  
4 incurred.

5 (f) Covered expense under this section need not include  
6 expense for dental or vision care, or other optional benefits not  
7 normally offered by the insurer under a major medical or  
8 comprehensive medical expense plan.

9 (g) *This section shall become inoperative on March 31, 2003,*  
10 *and, as of January 1, 2004, is repealed, unless a later enacted*  
11 *statute, that becomes operative on or before January 1, 2004,*  
12 *deletes or extends the dates on which it becomes inoperative and*  
13 *is repealed.*

14 SEC. 17. *Section 12685 of the Insurance Code is amended to*  
15 *read:*

16 12685. (a) The insurer may, at its option, offer alternative  
17 plans for group health conversion in addition to those required by  
18 this part.

19 (b) *This section shall become inoperative on March 31, 2003,*  
20 *and, as of January 1, 2004, is repealed, unless a later enacted*  
21 *statute, that becomes operative on or before January 1, 2004,*  
22 *deletes or extends the dates on which it becomes inoperative and*  
23 *is repealed.*

24 SEC. 18. *Section 12689 of the Insurance Code is amended to*  
25 *read:*

26 12689. A notification of the conversion coverage shall be  
27 included in each certificate of coverage or other legally required  
28 document explaining coverage; ~~provided, however, that.~~ *The*  
29 *health insurer shall provide the policyholder with the comparative*  
30 *benefit matrix prepared pursuant to Section 10127.14. However,*  
31 *it shall be the sole responsibility of the policyholder to notify its*  
32 *employees or members of the availability, terms, and conditions*  
33 *of conversion coverage which responsibility shall be satisfied by*  
34 *notification within 15 days of termination of group coverage. It*  
35 *shall also be the sole responsibility of the policyholder to distribute*  
36 *the comparative benefit matrix to its employees or members with*  
37 *this notice.* Group coverage shall not be deemed terminated until  
38 the expiration of any continuation of the group coverage. For  
39 purposes of this part, the policyholder shall not be deemed to be

1 the agent of the insurer for purposes of notification of the  
2 availability, terms, and conditions of conversion coverage.

3 *SEC. 19. Section 12711 of the Insurance Code is amended to*  
4 *read:*

5 12711. The board shall have the authority:

6 (a) To determine the eligibility of applicants.

7 (b) To determine the major risk medical coverage to be  
8 provided program subscribers.

9 (c) To research and assess the needs of persons not adequately  
10 covered by existing private and public health care delivery systems  
11 and promote means of assuring the availability of adequate health  
12 care services.

13 (d) To approve subscriber contributions, and plan rates, and  
14 establish program contribution amounts.

15 (e) To provide major risk medical coverage for subscribers or  
16 to contract with a participating health plan or plans to provide or  
17 administer major risk medical coverage for subscribers.

18 (f) To authorize expenditures from the fund to pay program  
19 expenses which exceed subscriber contributions.

20 (g) To contract for administration of the program or any portion  
21 thereof with any public agency, including any agency of state  
22 government, or with any private entity.

23 (h) To issue rules and regulations to carry out the purposes of  
24 this part.

25 (i) *To authorize expenditures from the fund or from other*  
26 *moneys appropriated in the annual Budget Act for purposes*  
27 *relating to Section 10127.15 of this code or Section 1373.62 of the*  
28 *Health and Safety Code.*

29 (j) To exercise all powers reasonably necessary to carry out the  
30 powers and responsibilities expressly granted or imposed upon it  
31 under this part.

32 *SEC. 20. Section 12712.5 is added to the Insurance Code, to*  
33 *read:*

34 *12712.5. (a) For the period commencing on March 31, 2003,*  
35 *to July 1, 2007, inclusive, the board shall maintain the major risk*  
36 *medical coverage benefits offered by participating health plans in*  
37 *the program at a level that is, at minimum, the actuarial equivalent*  
38 *of the lowest level of these benefits available within the program*  
39 *on March 31, 2003.*

1     **(b)** *This section shall become operative on March 31, 2003,*  
2 *and shall become inoperative on July 1, 2007. As of January 1,*  
3 *2008, this section is repealed, unless a later enacted statute, that*  
4 *becomes operative on or before January 1, 2008, deletes or*  
5 *extends the dates on which the section becomes inoperative and is*  
6 *repealed.*

7     **SEC. 21.** *Section 12725 of the Insurance Code is amended to*  
8 *read:*

9     12725. **(a)** Each resident of the state meeting the eligibility  
10 criteria of this section and who is unable to secure adequate private  
11 health coverage is eligible to apply for major risk medical  
12 coverage through the program. For these purposes, “resident”  
13 includes a member of a federally recognized California Indian  
14 tribe. ~~To~~

15     **(b)** *To be eligible for enrollment in the program, an applicant*  
16 *shall have been rejected for health care coverage by at least one*  
17 *private health plan. An applicant shall be deemed to have been*  
18 *rejected if the only private health coverage which that the*  
19 *applicant could secure would* ~~(1) impose~~ *do one of the following:*

20     **(1)** *Impose* substantial waivers ~~which that the program~~  
21 *determines would leave a subscriber without adequate coverage*  
22 *for medically necessary services, or* ~~(2) would afford such.~~

23     **(2)** *Afford* limited coverage, ~~as that the program determines~~  
24 *would leave the subscriber without adequate coverage for*  
25 *medically necessary services, or* ~~(3) would afford.~~

26     **(3)** *Afford* coverage only at an excessive price, which the board  
27 determines is significantly above standard average individual  
28 coverage rates. ~~Rejection~~

29     **(c)** *Rejection* for policies or certificates of specified disease or  
30 policies or certificates of hospital confinement indemnity, as  
31 described in Section 10198.61, shall not be deemed to be rejection  
32 for the purposes of eligibility for enrollment. ~~The~~

33     **(d)** *The board may permit dependents of eligible subscribers to*  
34 *enroll in major risk medical coverage through the program if the*  
35 *board determines the enrollment can be carried out in an*  
36 *actuarially and administratively sound manner.*

37     **(e)** *Notwithstanding the provisions of this section, the board*  
38 *shall by regulation prescribe a period of time during which a*  
39 *resident is ineligible to apply for major risk medical coverage*  
40 *through the program, if the resident either voluntarily disenrolls*

1 from, or was terminated for nonpayment of the premium from, a  
2 private health plan after enrolling in that private health plan  
3 pursuant to either Section 10127.15 or Section 1373.62 of the  
4 Health and Safety Code.

5 (f) For the period commencing March 31, 2003, to July 1, 2007,  
6 inclusive, subscribers and their dependents who become eligible  
7 for major risk coverage through the program may receive that  
8 coverage for no more than 36 consecutive months. Ninety days  
9 before a subscriber or dependent's eligibility ceases pursuant to  
10 this subdivision, the board shall provide the subscriber and any  
11 dependents with written notice of the termination date and written  
12 information concerning the right to purchase a standard benefit  
13 plan from any health care service plan or health insurer  
14 participating in the individual insurance market pursuant to  
15 Section 10127.15 or Section 1373.62 of the Health and Safety  
16 Code. This subdivision shall become inoperative on July 1, 2007.

17 SEC. 22. Section 12739 of the Insurance Code is amended to  
18 read:

19 12739. (a) There is hereby created in the State Treasury a  
20 special fund known as the Major Risk Medical Insurance Fund  
21 ~~which~~ that is, notwithstanding Section 13340 of the Government  
22 Code, continuously appropriated to the board for the purposes  
23 specified in ~~Section~~ Sections 10127.15 and 12739.1 and Section  
24 1373.62 of the Health and Safety Code.

25 (b) After June 30, 1991, the following amounts shall be  
26 deposited annually in the Major Risk Medical Insurance Fund:

27 (1) Eighteen million dollars (\$18,000,000) from the Hospital  
28 Services Account in the Cigarette and Tobacco Products Surtax  
29 Fund.

30 (2) Eleven million dollars (\$11,000,000) from the Physician  
31 Services Account in the Cigarette and Tobacco Products Surtax  
32 Fund.

33 (3) One million dollars (\$1,000,000) from the Unallocated  
34 Account in the Cigarette and Tobacco Products Surtax Fund.

35 SEC. 23. Section 12739.1 of the Insurance Code is amended  
36 to read:

37 12739.1. Except as provided in Section 12739.2, the board  
38 shall authorize the expenditure of money in the fund to cover  
39 program expenses, including program expenses ~~which~~ that exceed  
40 subscriber contributions, and to cover expenses relating to Section

1 10127.15, or to Section 1373.62 of the Health and Safety Code.  
2 The board shall determine the amount of funds expended for each  
3 of these purposes, taking into consideration the requirements of  
4 this part, Section 10127.15, and Section 1373.62 of the Health and  
5 Safety Code.

6 SEC. 24. Section 12739.2 of the Insurance Code is amended  
7 to read:

8 12739.2. From money appropriated by the Legislature to the  
9 fund, the board may expend sufficient funds to carry out the  
10 purposes of this part and of Section 10127.15 and Section 1373.62  
11 of the Health and Safety Code.

12 However, the state shall not be liable beyond the assets of the  
13 fund for any obligations incurred, or liabilities sustained, in the  
14 operation of the California Major Risk Medical Insurance  
15 Program or for the expenditures described in Section 10127.15  
16 and Section 1373.62 of the Health and Safety Code.

17 SEC. 25. The Managed Risk Medical Insurance Board shall  
18 have the authority to issue rules and to adopt regulations to  
19 implement the provisions of this act and to exercise all powers  
20 reasonably necessary to carry out the powers and responsibilities  
21 expressly granted or imposed upon it under this act. Until July 1,  
22 2004, any rules and regulations issued by the board pertaining to  
23 the implementation of this act may be adopted as emergency  
24 regulations in accordance with the Administrative Procedure Act  
25 (Chapter 3.5 (commencing with Section 11340) of Part 1 of  
26 Division 3 of Title 2 of the Government Code). The adoption and  
27 one readoption of these regulations shall be deemed to be an  
28 emergency and necessary for the immediate preservation of the  
29 public peace, health, and safety, or general welfare and shall be  
30 exempt from review by the Office of Administrative Law. Any  
31 emergency regulations authorized by this section shall be  
32 submitted to the Office of Administrative Law for filing with the  
33 Secretary of State and publication in the California Code of  
34 Regulations and shall remain in effect for no more than 180 days.  
35 The regulations shall become effective immediately upon filing  
36 with the Secretary of State.

37 SEC. 26. (a) The Legislative Analyst shall study and evaluate  
38 the provisions of this act, including the pilot program described in  
39 Section 1373.62 of the Health and Safety Code and Section  
40 10127.15 of the Insurance Code, to determine their effectiveness

1 *in providing coverage to individuals who are otherwise unable to*  
2 *obtain health benefits and the act's impact on the accessibility and*  
3 *affordability of health benefits. The evaluation shall include,*  
4 *based on information provided by the Managed Risk Medical*  
5 *Insurance Board, health care service plans and health insurers, all*  
6 *of the following:*

7 *(1) The number of individuals receiving coverage under the*  
8 *California Major Risk Medical Insurance Program pursuant to*  
9 *the provisions of this act by calendar year compared with the*  
10 *enrollment in the program in the four calendar years prior to the*  
11 *enactment of this act.*

12 *(2) The number of individuals receiving coverage under the*  
13 *provisions of this act after leaving the California Major Risk*  
14 *Medical Insurance Program.*

15 *(3) The number of individuals receiving conversion coverage*  
16 *under the provisions of this act.*

17 *(4) The number of individuals receiving Cal-COBRA coverage*  
18 *under the provisions of this act.*

19 *(5) The number of individuals receiving coverage under the*  
20 *provisions of the Health Insurance Portability and Accountability*  
21 *Act of 1996 and the provisions of Article 4.6 (commencing with*  
22 *Section 1366.35) and Article 10.5 (commencing with Section*  
23 *1399.801) of Chapter 2.2 of Division 2 of the Health and Safety*  
24 *Code, and the provisions of Chapter 8.5 (commencing with Section*  
25 *10785) and Chapter 9.5 (commencing with Section 10900) of Part*  
26 *2 of Division 2 of the Insurance Code, and Section 10844 of the*  
27 *Insurance Code.*

28 *(6) Whether the cost of coverage under the California Major*  
29 *Risk Medical Insurance Program and for individuals leaving the*  
30 *program for guaranteed issue coverage should be changed.*

31 *(7) Whether the level of benefits provided under the California*  
32 *Major Risk Medical Insurance Program and for individuals*  
33 *leaving the program for guaranteed issue coverage should be*  
34 *changed.*

35 *(8) The affect of this act on the affordability and accessibility*  
36 *of health insurance in the individual health insurance market.*

37 *(b) The Legislative Analyst shall report the results of the study*  
38 *and evaluation to the appropriate policy and fiscal committees of*  
39 *the Legislature on or before June 30, 2005, and shall include in the*  
40 *report any recommendations for changes to the pilot program,*

1 *including whether it should continue beyond its designated*  
2 *termination date.*

3 *SEC. 27. No reimbursement is required by this act pursuant*  
4 *to Section 6 of Article XIII B of the California Constitution*  
5 *because the only costs that may be incurred by a local agency or*  
6 *school district will be incurred because this act creates a new crime*  
7 *or infraction, eliminates a crime or infraction, or changes the*  
8 *penalty for a crime or infraction, within the meaning of Section*  
9 *17556 of the Government Code, or changes the definition of a*  
10 *crime within the meaning of Section 6 of Article XIII B of the*  
11 *California Constitution.*

12  
13  
14 **All matter omitted in this version of the**  
15 **bill appears in the bill as amended in the**  
16 **Senate, August 20, 2001 (JR 11)**  
17  
18

